ARIZONA AIDS DRUG ASSISTANCE PROGRAM (ADAP)
VALGANCICLOVIR APPLICATION

Client Name _____ **Date of Application** _____

General Indications

Are you going to be using valganciclovir as a primary prophylaxis for this client?
☐ Yes ☐ No

Are you going to be using valganciclovir for secondary prevention of CMV infection?
☐ Yes ☐ No

How was CMV disease documented? _____

_____

*Most recent serum creatinine _____ Date obtained _____

Calculated creatinine clearance _____

*****Most recent viral load _____ Date obtained _____

*****Most recent CD4 count _____ Date obtained _____

*Most recent white blood count _____ Date obtained _____

*Most recent hemoglobin/hematocrit count _____ Date obtained _____

*Most recent platelet count _____ Date obtained _____

***Please attach or fax most recent serum creatinine, viral load, CD4 count, white blood count, hemoglobin/hematocrit count and platelet count lab reports.**

☐ Patient will have repeat HIV RNA and CD4 counts performed 12 and 24 weeks after initiation of valganciclovir to assess the duration of therapy.

If this patient does not meet current ADAP guidelines for valganciclovir use, please provide information regarding the medical necessity and justification for use. _____

_____

Physician Signature** _____

**If submitting electronically, typing your name will serve as an electronic signature.

Please submit this form to the ADAP office by e-mail (krogerl@azdhs.gov) or fax (602)364-3263. If submitting electronically, please save the file as a unique, identifiable file name. Copies of lab reports may be faxed if electronic copies are not available. HIPAA regulations must be followed when transmitting documents with patient-identifying information. If you have any questions, please call (602)364-3594.